3 Aged and Disabled Waiver Guidelines

3.1 Introduction

3.1.1 Overview

Idaho's elderly and disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the person's own home and/or community regardless of age, income, or ability. These services should encourage the involvement of natural supports such as family, friends, neighbors, volunteers, religious community, and others. To this end, the Department's Medicaid program requested and obtained a Home and Community-Based Services (HCBS) waiver from the federal government.

The HCBS waiver allows the provision of services that may be provided in a number of community living situations, such as:

- the person's own home or apartment
- the home of relatives who are the primary non-paid care providers\
- certified family homes (for additional information refer to Chapter 19.3.14.3)
- residential care facilities
- assisted living facilities

This section covers all Medicaid services provided through Waiver Services for Aged and Disabled (A&D) Waiver as deemed appropriate by Medicaid including:

- Adult day care
- Adult residential care
- Non-medical transportation
- Specialized medical equipment and supplies
- Attendant care
- Psychiatric consultation services
- Case Management
- Chore services
- Companion services
- Consultation services
- Homemaker services
- Home delivered meal services
- Environmental accessibility adaptations
- Respite care services
- Nursing services
- Personal emergency response system services

Note: Aged and Disabled Waivered services are covered for Medicaid Enhanced Plan Benefits participants.

Note: Aged and Disabled Waivered services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** particpants.

Note: Aged and Disabled Waivered services are covered for **Medicaid Enhanced Plan Benefits** participants.

3.1.1.1 Regional Medicaid Services

In order to better serve the public, the state is organized into seven regions to provide programs that foster a productive, healthful and independent quality of life for Idaho citizens. Each region serves several counties.

Regional Medicaid Services (RMS) is a unit of the Division of Medicaid in the region that acts as the administrative case manager for the Aged and Disabled Waiver. They determine unmet needs through the Uniform Assessment Instrument, authorize waiver services, and develop an Individual Service Plan.

3.1.2 General Information

This section covers all general claims information for Waiver Services for Aged and Disabled Adults (A&D Waiver).

It addresses the following:

- Provider qualifications
- Record keeping
- Participant eligibility
- Prior authorization
- Billing information
- Place of service delivery and exclusions
- Plan for Services
- Change of provider information

3.1.2.1 Provider Qualifications

All providers of services must have a valid provider agreement or performance contract with Medicaid. Providers must meet the qualifications of IDAPA 16.03.09.796. The RMS in each region will monitor performance under this agreement or contract.

- Attendant care, respite, companions, and other waiver service providers must obtain a separate provider number for transportation services.
- Non-Medical Transportation Services providers must be enrolled as transportation vendors with the Idaho Medicaid program; see Section 3.4 for more information.
- Specialized Medical Equipment and Supplies Services providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see Section 3.5 for more information.
- Environmental Accessibility Adaptation providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see Section 3.14 for more information.
- Personal Emergency Response System Services providers must be enrolled as medical equipment vendors with the Idaho Medicaid program; see Section 3.17 for more information.

3.1.2.2 Record Keeping

Medicaid requires all providers to meet the documentation requirements listed in the provider enrollment agreement and IDAPA rules. Providers must generate records at the time of service and maintain all records necessary to

fully document the extent of services submitted for Medicaid reimbursement. Providers must also retain all medical records to document services submitted for Medicaid reimbursement for at least five years after the date of service.

3.1.2.3 Participant Eligibility

For a participant to be eligible for Medicaid payment of waiver services, the RMS must determine that all of the following criteria are met:

The participant requires services due to a physical or cognitive disability, which results in a significant impairment in functional independence as demonstrated by the findings of a Uniform Assessment Instrument (UAI).

The participant is capable of being maintained safely and effectively in a non-institutional setting.

The participant would need to reside in a nursing facility in the absence of waiver services. Medicaid program expenditures for the care of the person in the community will be no more than the Medicaid program costs would be for that person's care in a nursing facility.

3.1.2.4 Prior Authorization

Regional Medicaid Services (RMS) must authorize all services reimbursed by Medicaid under the A&D Waiver program before services are rendered. Approved prior authorizations are valid for one year from the date of prior authorization by the RMS unless otherwise indicated.

The prior authorization number must appear on all claims or they will be denied. Exception: providers billing code S5140-U2 (Adult Residential Care) do **not** need to include the PA number on the claim.

Refer to **General Billing Information Section 2.3** for additional billing information.

3.1.2.5 Healthy Connections

Healthy Connection referrals are **not** required for services under the A&D Waiver.

3.1.2.6 Place of Service Delivery and Exclusions

Participants may choose to receive A&D Waiver services in the following environments:

- Participant's own home or apartment
- Certified Family Home
- Residence of the participant's family
- Day care
- Residential Care and Assisted Living Facilities
- The community

The following living situations are specifically **excluded** as a personal residence for A&D waiver services:

- Licensed, skilled, or intermediate care facility
- Certified nursing facility (NF) or hospital

- Licensed intermediate care facility for the mentally retarded (ICF/MR)

3.1.2.7 Individual Service Plan (ISP)

All services must be prior authorized by the RMS in the region where the participant resides. The services must be based on a written Individual Service Plan (ISP).

The RMS or its contractor and the participant develop the ISP for the A&D Waiver. In addition, the following persons may be included:

- the PCS case manager or RN Supervisor
- the guardian, family, or current service providers, unless specifically excluded by the participant
- others identified by the participant

The ISP is based on a person-centered, planning and assessment process using the UAI and the participant's choice of services. It describes the specific types, amounts, frequency, and duration of Medicaid-reimbursed services to be provided. It lists the support and service needs to be met by the participant's family, friends, other community resources, and the providers of services, when known.

The ISP must include documentation of the participant's choice between waiver services and institutional placement and the participant's or a legal guardian's signature (if applicable).

The ISP must be revised and updated by the RMS based upon significant changes in the participant's needs and be re-authorized at least annually.

The ISP includes all Medicaid allowable services and supports, and all natural or non-paid services and supports. See Idaho Administrative Procedures Act (IDAPA), sections 16.03.09.664-704, for supervision requirements for each participant service.

3.1.2.8 Change of Provider Information

Notify EDS Provider Enrollment in writing when there are changes to your status as a provider. Do not indicate changes on a claim form. Include in the written notice your provider name and current Medicaid provider number. Status changes include:

- Change in address
- New phone number
- Name change (individual, group practice, etc.)
- Change in ownership
- Change in tax identification information
- Additions or deletions to a group or agency

Use the Change of Address form available in the Forms Appendix and mail to:

EDS
Provider Enrollment
P.O. Box 23
Boise, ID 83707

3.2 Adult Day Care

3.2.1 Overview

Adult day care is a supervised, structured day program outside of the home of the participant that may offer one or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. All services must be prior authorized by the RMS prior to payment.

Note: Adult Day Care services are covered for Medicaid Enhanced Plan Benefits participants

3.2.2 Facilities

Facilities that provide adult day care must be maintained in a safe and sanitary manner and meet the requirements of the Adult Day Care Provider Agreement. Facilities will provide the staff and space necessary to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary to assure the comfort and safety of the participants served.

3.2.2.1 Provider Home (Certified Family Home)

Providers accepting participants into their home for services must maintain the home in a safe and sanitary manner and meet the standards of the Adult Day Care Provider Agreement and home certification identified in the Rules Governing Certified Family Homes IDAPA 16.03.19. The provider must provide supervision as necessary to assure the comfort and safety of the participants served.

3.2.3 Diagnosis Code

Enter the ICD-9-CM code **V604 –** "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 claim form or in the appropriate field of the electronic claim.

3.2.4 Place of Service Codes

Adult Day Care services can only be provided in the following places of service:

12 – Home

99 – Other Place of Service (Community)

Enter this information in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim.

3.2.5 Procedure Code

Use the five-digit HCPCS procedure code when billing Adult Day Care services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Adult Day Care	0644P	S5100 U2 modifier required	Day Care Services, Adult 1 Unit = 15 minutes

3.3 Adult Residential Care (ARC)

3.3.1 Overview

Adult Residential Care (ARC) consists of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22 or IDAPA 16.03.19. Locations can include: certified family home, assisted living facility, residential care facility, or other facility where care is provided commercially.

The service need identified by the Uniform Assessment Instrument (UAI) is negotiated between the facility and the participant and may include medication management, assistance with activities of daily living, meals (including special diets), housekeeping, laundry, transportation, opportunities for socialization, recreation, and assistance with personal finances. Administrative oversight must be provided for all services provided or available in this setting.

A negotiated service agreement will be developed between the participant, or the participant's legal representative, and a facility representative. While in this setting, the participant will not be eligible for other waiver services except for nursing services, consultation, behavior consultation, and assistive technology.

Note: Adult Residential Care services are covered for Medicaid Enhanced Plan Benefits participants.

3.3.2 Provider Qualifications

The facility must meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff is provided to meet the needs of all participants accepted for admission on a 24 hour, seven days per week basis.

3.3.3 Payment

Payment will be made on a *per diem* basis. The daily payment rate will be established by the RMS based on the hours of service established in a negotiated service agreement and on the findings of the UAI.

3.3.4 Diagnosis Code

Enter the ICD-9-CM code **V604 -** "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.3.5 Place of Service Code

Adult Residential Care services can only be provided in the following place of service:

33 – Custodial Care Facility (certified family homes, assisted living facilities, residential care facilities, and other living situations where care is furnished commercially)

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.3.6 Procedure Code

Use the five-digit HCPCS procedure code when billing Adult Residential Care services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Adult Residential Care	0661P	S5140 U2 Modifier Required	Foster Care, Adult 1 unit = 1 day of service

3.4 Non-Medical Transportation

3.4.1 Overview

Non-Medical Transportation consists of individual assistance with non-Medical transportation services, including an escort for a participant who has difficulties (physical or cognitive), using regular vehicular transportation. The services must be specified in an Individual Service Plan to enable the participant to gain access to waiver and other community services and resources.

Note: Non-Medical Transportation Waivered services are covered for Medicaid Enhanced Plan Benefits participants.

3.4.2 Provider Qualifications

The provider must be enrolled as a waiver provider and have a valid driver's license and liability insurance for the vehicle operated.

3.4.3 Payment

Payment for Non-Medical Waiver transportation is reimbursed at the per-mile rate established by Medicaid. Providers and participants receive a prior authorization notice that identifies the procedure codes that have been approved and are to be used for billing. The prior authorization number must appear on the claim or the claim will be denied.

3.4.4 Diagnosis Code

Enter the ICD-9-CM code **V604** - "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.4.5 Place of Service Code

Non-medical transportation can only be provided in the following place of service:

99 – Other Place of Service (Community)

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.4.6 Procedure Code

Use the five-digit HCPCS procedure code when billing non-medical transportation services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Codes (Effective 10/20/03)	New Description
A&D non-medical Transportation	0080P	A0080 U2 Modifier Required	Non-emergency transportation, per mile-vehicle provided by volunteer (individual or organization), with no vested interest. 1 unit = 1 mile

3.5 Specialized Medical Equipment and Supplies

3.5.1 Overview

Specialized Medical Equipment and Supplies (SME) is any item, piece of equipment or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. SME also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. These services are authorized by the Medicaid DME unit.

For additional information regarding provider and billing criteria, refer to the Durable Medical Equipment Provider Handbook under the Waiver Services section.

Note: Specialized Medical Equipment and Supplies for Aged and Disabled Waivered services are covered for Medicaid Enhanced Plan Benefits participants

3.6 Attendant Care

3.6.1 Overview

Attendant Care consists of services that involve personal and medically oriented tasks dealing with the functional needs of the participant. Most care is self-directed by the participant.

These services may include personal tasks and medically related tasks that may be done by unlicensed persons, or delegated to unlicensed persons by a health care professional. In addition, it may include administration of medications, ventilator care, and tube feedings.

Services may occur in the participant's home, community, work, or school settings as authorized in the Department's approved Plan for Services.

Note: Attendant Care for Aged and Disabled Waivered services are covered for Medicaid Enhanced Plan Benefits participants

3.6.2 Provider Qualifications

An employee of an agency or fiscal intermediary must provide services. A provider employed by a fiscal intermediary is selected, trained, and supervised by the participant or participant's family.

3.6.3 Diagnosis Code

Enter the ICD-9-CM code **V604** - "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.6.4 Place of Service Codes

Attendant Care can only be provided in the following places of service:

03 – School

12 – Home

33 – Custodial Care Facility (certified family homes, assisted living facilities, residential care facility, and other living situations where care is furnished commercially) when the negotiated service agreement does not identify this service as the responsibility of the facility

99 – Other Place of Service (Community)

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.6.5 Procedure Code

Use the five-digit HCPCS procedure code when billing Attendant Care services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Codes (Effective 10/20/03)	New Description
Attendant Care	0646P	S5125 U2 modifier required	Attendant Care Services 1 unit = 15 minutes

3.7 Psychiatric Consultation

3.7.1 Overview

Psychiatric Consultation Services provide direct consultation and clinical evaluation of participants who are currently experiencing, or may be expected to experience, a psychological, behavioral, or emotional crisis.

This service may provide training and staff development related to the needs of the participant.

These services also provide emergency back up involving the direct support of the participant in crisis.

Note: Psychiatric Consultation for Aged and Disabled Waivered services are covered for Medicaid Enhanced Plan Benefits participants.

3.7.2 Provider Qualifications

Services must be provided by an employee of an agency, fiscal intermediary, or individual. The provider must have one of the following:

- a Master's degree in a behavioral science and is licensed in accordance with State law to provide psychiatric services
- a bachelor's degree, work for an agency with direct supervision from a licensed or Ph.D. psychologist, and have one (1) year of experience in treating severe behavior problems

3.7.3 Diagnosis Code

Enter the ICD-9-CM code **V604 -** "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.7.4 Place of Service Codes

Psychiatric Consultation can only be provided in the following places of service:

03 – School

11 – Office

12 – Home

33 – Custodial Care Facility (Certified family home, assisted living facility, residential care facility or other facility where care is provided commercially)

99 – Other Place of Service (Community, Adult Day Care)

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.7.5 Procedure Code

Use the five-digit HCPCS procedure code when billing Psychiatric Consultation services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Psychiatric Consultation	0651P	90899 U2 modifier required	Unlisted Psychiatric Service or procedure 1 unit = 15 minutes

3.8 Case Management

3.8.1 Overview

Case management (CM) is a service designed to foster the independence of the participant by demonstrating to the individual how to best access service delivery systems such as energy, legal, or financial assistance. Case management services are delivered by qualified providers to assist Medicaid participants to obtain needed health and social services. Case Managers must meet the provisions of IDAPA 16.03.17, "Service Coordination."

Note: Case Management services are covered for Medicaid Enhanced Plan Benefits participants.

3.8.2 Service Delivery

All individual case managers must be employees of an organized entity that has a valid provider agreement on file with Idaho Medicaid. Agreements are negotiated and monitored by the Regional Medicaid Service (RMS) unit.

The case management agency cannot provide personal care services and case management services to the same participant.

3.8.2.1 Provider Qualifications

The employing entity will supervise individual case management providers and assure that the following qualifications are met:

- must be a licensed social worker; or licensed professional nurse (R.N.); or have at least a BA or BS in a human services field and at least one (1) year's experience in service delivery to the service population.
- must be supervised by an individual who has at least a BA or BS degree and is a licensed social worker, psychologist or licensed professional nurse (registered nurse) with at least two years experience in service delivery to the service population or a masters degree in a human services field and one year's experience with the population for which he/she will be supervising services. The supervisor will oversee the service delivery and have the authority and responsibility to remove the individual case manager if the participant's needs are not met.

The case management agency must demonstrate:

- Capacity to provide all services
- Experience with target population

Appropriate personnel practices, including but not limited to, conducting an orientation program for all new employees that covers at least the local resources available, case management service delivery, confidentiality of information, and participant rights.

3.8.3 Case Manager's Responsibilities

The case manager will have face-to-face contact with the participant at least once each month. The frequency, mode of contact, and person being contacted must be identified in the ISP. Case management services will

consist of assessing the individual's needs and developing and implementing the case management plan.

3.8.3.1 Assessing the Participant's Needs

To assess a participant's needs, the case manager will conduct a comprehensive evaluation of the participant's ability to function in the community, including but not limited to:

- Medical needs
- Physical problems and strengths
- Mental and emotional problems and strengths
- Physical living environment
- Vocational and educational needs
- Financial and social needs
- Safety and risk factors
- Legal status
- Evaluation of the community support system including the involvement of family or significant other persons

3.8.3.2 Developing and Implementing the Individual Community Support Plan

The Individual Community Support Plan (ICSP) development is based on the information obtained during the participant assessment and input from involved professionals. Case managers must update the ICSP as least annually and get continued approval from the RMS, if appropriate. A copy of the current ICSP must be provided to the participant or his/her legal representative.

Case managers develop a written plan that covers:

- Problems identified during the assessment
- Overall goals to be achieved
- All services and contributions provided by the informal support system, including the actions, if any, taken by the case manager to develop the support system
- Documentation of who has been involved in the service planning, including the participant's involvement
- Schedule for case management monitoring and reassessment
- Documentation of unmet needs and service gaps
- Reference to any formal services arranged, including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery

3.8.4 Diagnosis Code

Enter the ICD-9-CM code **V604 -** "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.8.5 Place of Service Codes

Enter the appropriate numeric code in the place of service box on the CMS 1500 claim form or in the appropriate field when billing electronically.

11 – Office

12 – Home

99 – Other Place of Service (Community)

3.8.6 Procedure Codes

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Case Management	0516P	G9001 U2 modifier required	Coordinated Care Fee, Initial Rate Assessment and ICSP. This is a one-time rate. 1 unit = ICSP development
Ongoing and emergency case management	0515P	G9002 U2 modifier required	Coordinated Care Fee, Maintenance Rate Maximum of 8 hours per month unless approved by the RMS. Indicate the total number of units billed. 1 unit = 15 minutes

3.8.7 Prior Authorization

The RMS must approve the participant for case management services and prior authorize all case management services including the assessment and service plan development.

3.8.8 Record Requirements

The provider must maintain the following documentation:

- Name of the participant
- Name of agency and person providing service
- A copy of the assessment and service plan
- Place of service
- Date, time, and duration of service
- Activity record describing the participant or community contact

3.9 Chore Services

3.9.1 Overview

Chore Services consist of intermittent assistance including, but not limited to, yard maintenance, minor home repair, heavy housework, sidewalk maintenance, and trash removal to assist the participant to remain in his or her home.

These services are available only when neither the participant nor any one else in the household is capable of performing the service, and when no other relative, caretaker, landlord, community volunteer, or third party payer is willing or is responsible for their provision.

Chore services are limited to being provided in a home either rented or owned by the participant.

Chore activities include:

- washing windows
- moving heavy furniture
- shoveling snow to provide safe access inside and outside the home
- chopping firewood when wood is the participant's primary source of heat
- tacking down loose rugs and flooring

Note: Attendant Care for Aged and Disabled Waivered services are covered for Medicaid Enhanced Plan Benefits participants.

3.9.2 Provider Qualifications

Services must be provided by an employee of an agency or fiscal intermediary. A provider employed by a fiscal intermediary is selected, trained and supervised by the participant or the participant's family.

3.9.3 Diagnosis Code

Enter the ICD-9-CM code **V604** - "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.9.4 Place of Service Code

Chore Services can only be provided in the following place of service:

12 – Home

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.9.5 Procedure Code

Use the five-digit HCPCS procedure code when billing Chore Services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Chore Services	0648P	S5120 U2 modifier required	Chores Services 1 unit = 15 minutes

3.10 Companion Services

3.10.1 Overview

Companion Services are in-home services provided to insure the safety and well being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond in emergency situations or other conditions that would require a person on-site. The provider may give voice cueing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living as required. However, the major responsibility is to provide companionship and to be there in case assistance is needed. The service may be intermittent or regular, depending on the needs of the individual.

Note: Companion services are covered for Medicaid Enhanced Plan Benefits participants.

3.10.2 Provider Qualifications

An employee of an agency or fiscal intermediary must provide services. A provider employed by a fiscal intermediary is selected, trained, and supervised by the participant or participant's family.

3.10.3 Diagnosis Code

Enter the ICD-9-CM code **V604 -** No Other Household Member Able to Render Care, for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.10.4 Place of Service Code

Companion Services can only be provided in the following place of service:

12 – Home

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.10.5 Procedure Code

Use the five-digit HCPCS procedure code when billing Companion services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Companion	0649P	S5135 U2 modifier required	Companion Care, adult 1 unit = 15 minutes Limited to $25.00/day

3.11 Consultation Services

3.11.1 Overview

Consultation Services are provided by an agency or fiscal intermediary to a participant or family member. The purpose of Consultation Services to a participant is to increase the skill of the participant or family member as an employer or manager of the participant's care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and family. Services given to the caregiver are for the purpose of understanding the special needs of the participant and the role of the caregiver.

Note: Consultation services are covered for Medicaid Enhanced Plan Benefits participants.

3.11.2 Provider Qualifications

Services must be provided by an employee of an agency or fiscal intermediary who is capable of performing the duties required based on the Plan for Services.

3.11.3 Diagnosis Code

Enter the ICD-9-CM code **V604** - "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.11.4 Place of Service Codes

Consultation Services can only be provided in the following places of service:

03 – School

11 – Office

12 – Home

33 – Custodial Care Facility (Certified family home, assisted living facility, residential care facility, or other facility where care is provided commercially)

99 – Other Place of Service (Community, Adult Day Care)

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.11.5 Procedure Code

Use the five-digit HCPCS procedure code when billing Consultation services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Consultation	0658P	S5115 U2 modifier required	Home Care Training – non family 1 unit = 15 minutes

3.12 Homemaker Services

3.12.1 Overview

Homemaker Services assist the participant with light housekeeping, laundry, essential errands, meal preparation, and other light housekeeping duties when there is no one else in the household capable of performing these tasks.

Note: Homemaker services are covered for Medicaid Enhanced Plan Benefits participants.

3.12.2 Provider Qualifications

Services must be provided by an employee of an agency or fiscal intermediary who is capable of performing the duties required based on the Individual Service Plan.

3.12.3 Diagnosis Code

Enter the ICD-9-CM code **V604 –** "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.12.4 Place of Service Code

Homemaker services can only be provided in the following place of service:

12 – Home

Enter this information in field 24B on the CMS-1500, or in the appropriate field of the electronic claim.

3.12.5 Procedure Code

Use the five-digit HCPCS procedure code when billing Homemaker services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Homemaker Services	0652P	S5130 U2 modifier required	Homemaker Service, NOS 1 unit = 15 minutes

3.13 Home Delivered Meal Services

3.13.1 Overview

Home Delivered Meal Services are designed to promote adequate participant nutrition through the provision and home delivery of one or two meals per day. Home delivered meals are limited to participants who:

- rent or own their own home
- are alone for significant parts of the day
- have no regular caregiver for extended periods of time
- are unable to prepare a balanced meal

Note: Home Delivered Meal services are covered for Medicaid Enhanced Plan Benefits participants.

3.13.2 Provider Qualifications

Services of home delivered meals under this section may only be provided by an agency capable of supervising the direct service. The agency must meet the following requirements:

- Ensure that each meal meets one third of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council of the National Academy of Sciences.
- Maintain registered dietitian documented review and approval of all menus, menu cycles, and any changes or substitutions.
- Deliver the meals in accordance with the plan for services in a sanitary manner and at the correct temperature for the specific type of food.
- Ensure that the meals are delivered on time.
- Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest USDA Grade for each specific food served.
- Provide documentation of current driver's license for each driver.
- Be licensed and inspected as a food establishment by the district health department.

3.13.3 Diagnosis Code

Enter the ICD-9-CM code **V604** – "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.13.4 Place of Service Code

Home delivered meals services can only be provided in the following place of service:

12 – Home

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.13.5 Procedure Code

Use the five-digit HCPCS procedure code when billing Home Delivered Meal services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Home Delivered Meals	0653P	S5170 U2 modifier required	Home Delivered Meals, including preparation 1 unit = 1 meal

3.14 Environmental Accessibility Adaptations

3.14.1 Overview

Environmental Accessibility Adaptations Services consist of minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization.

Such adaptations may include:

- installation of ramps and lifts
- widening of doorways
- modification of bathroom facilities
- installation of electrical or plumbing systems which are necessary to accommodate the medical equipment necessary for the welfare of the participant

Excluded are those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning.

Environmental modification services must be completed with a permit or other applicable requirements of the city, county, or state in which the modifications are made. The provider must demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes.

Permanent modifications are limited to a home owned by the participant or the participant's family when the home is the participant's primary residence. Portable or non-stationary modifications may be made when such modification can follow the participant to his or her next place of residence or be turned over to the Department.

Note: Environmental modification services are covered for Medicaid Enhanced Plan Benefits participants.

3.14.2 Provider Qualifications

Services must be provided by an individual or business properly licensed or certified to perform the necessary home modifications. Building inspections will be performed as necessary and documentation of the results must be provided to the RMS. Providers must be enrolled as a waiver provider with the Medicaid.

3.14.3 Payment

Payment for environmental accessibility adaptations will be made as prior-authorized by Medicaid. Each item and the allowed payment amount must be authorized. Providers and participants will receive a prior authorization notice, along with a prior authorization number that will identify the procedure codes, items, and the payment amount that have been approved and are to be used for billing. This prior authorization number must appear on the claim or the claim will be denied.

3.14.4 Diagnosis Code

Enter the ICD-9-CM code V604 – "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.14.5 Place of Service Code

Environmental Accessibility Adaptations Services can only be provided in the following place of service:

12 – Home

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.14.6 Procedure Code

Use the five-digit HCPCS procedure code when billing Environmental Accessibility Adaptations services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
Environmental Accessibility Adaptations	0669P	S5165 U2 modifier required	Home Modification; per service Environmental Accessibility Adaptations Services, per item and dollar amount as authorized by Medicaid

3.15 In-Home Respite Services

3.15.1 Overview

In-Home Respite Services provide occasional breaks from care-giving responsibilities for non-paid caregivers. The caregiver or participant is responsible for the selection, training, and directing of the provider. While receiving respite care services, the participant cannot receive other duplicate waiver services. Respite Care Services provided under the waiver will not include room and board payment.

Note: Respite services are covered for Medicaid Enhanced Plan Benefits participants.

3.15.2 Provider Qualifications

Services must be provided by an employee of an agency or fiscal intermediary who is capable of performing the duties required based on the Plan for Services.

3.15.3 Diagnosis Code

Enter the ICD-9-CM code **V604 -** "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.15.4 Place of Service Code

In-home respite can only be provided in the following place of service:

12 – Home

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.15.5 Procedure Code

Use the five-digit HCPCS procedure code when billing In-Home Respite services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Code (Prior to 10/20/03)	New HCPCS Code (Effective 10/20/03)	New Description
In-Home Respite	0655P	T1005 U2 modifier required	Respite Care Services 1 unit = 15 minutes

3.16 Nursing Services

3.16.1 Overview

Nursing Services consist of intermittent or continuous oversight, training, or skilled care within the scope of the Nurse Practice Act. These services are not appropriate if they are less cost effective than a home health visit. Nursing services may include, but are not limited to:

- insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material
- maintenance of volume ventilators including the associated tracheotomy care and oral pharyngeal suctioning
- maintenance and monitoring of I.V. fluids and/or nutritional supplements which are to be administered on a continuous or daily basis
- injections
- blood glucose monitoring
- blood pressure monitoring

Note: Nursing services for Aged and Disabled Waivered services are covered for Medicaid Enhanced Plan Benefits participants.

3.16.2 Provider Qualifications

Nursing services must be provided by a licensed registered nurse, or a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in Idaho, or be practicing on a federal reservation and be a licensed registered nurse in another state. In addition, they must be an employee of an agency or fiscal intermediary.

3.16.3 Diagnosis Code

Enter the appropriate ICD-9-CM code for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.16.4 Place of Service Codes

Nursing services can only be provided in the following places of service:

03 – School

12 – Home

33 – Custodial Care Facility, if such services are not included in the negotiated service agreement with the facility

99 – Other Place of Service (Adult Day Care)

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.16.5 Procedure Codes

Use the five-digit HCPCS procedure code when billing Nursing services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Codes (Prior to 10/20/03)	New HCPCS Codes (Effective 10/20/03)	New Description
Nursing Services – R.N.	0656P	T1002 U2 modifier required	RN Services 1 unit = 15 minutes
Aged and Disabled Nursing Service	0670P	T1001 U2 modifier required	Nursing Assessment/Evaluation RN service 1 unit = 1 visit
Nursing Services – L.P.N.	0657P	T1003 U2 modifier required	LPN/LVN Services 1 unit = 15 minutes

3.17 Personal Emergency Response System (PERS) Services

3.17.1 Overview

Personal Emergency Response System Services (PERS) consists of a system that may be provided to monitor participant safety and/or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who meet the following conditions:

- Rent or own their home
- Are alone for significant parts of the day
- Have no regular caregiver for extended periods of time
- Would otherwise require extensive routine supervision

Note: Personal Emergency Response System Services are covered for Medicaid Enhanced Plan Benefits participants.

3.17.2 Provider Qualifications

Providers must be enrolled as medical equipment vendors in the Idaho Medicaid program and be able to provide, install, and maintain the necessary equipment and operate a response center capable of responding on a 24 hour, 7 days per week basis.

Specific billing instructions can be found in Section 3 of the *Idaho Medicaid Provider Handbook* for medical equipment vendors.

3.17.3 Diagnosis Code

Enter the ICD-9-CM code **V604 -** "No Other Household Member Able to Render Care", for the primary diagnosis in field 21 on the CMS-1500 or in the appropriate field of the electronic claim.

3.17.4 Place of Service Code

PERS can only be provided in the following place of service:

12 – Home

Enter this information in field 24B on the CMS-1500 or in the appropriate field of the electronic claim.

3.17.5 Procedure Codes

Use the 5-digit HCPCS procedure code when billing Personal Emergency Response System services. Enter this information in field 24D on the CMS-1500 claim form or in the appropriate field of the electronic claim.

Service	Old Codes (Prior to 10/20/03)	New HCPCS Codes (Effective 10/20/03)	New Description
System Installation	0659P	S5160 U2 Modifier Required	Emergency Response System; installation and testing.
Monthly Rent	0660P	S5161 U2 Modifier Required	Emergency Response System; service fee, per month (excludes installation and testing).

3.18 Claim Billing

3.18.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.18.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.18.2.1 Guidelines for Electronic Claims

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a participant is referred by another provider. Use the referring providers' Medicaid provider number, unless the participant is a Healthy Connections participant. For Healthy Connections participants, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number on an electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.18.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms (formerly known as the HCFA 1500) to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

The CMS-1500 form can be used without changes for dates in the year 2000 and beyond. All dates must include the month, day, century, and year.

Example*:* July 4, 2005 is entered as 07/04/2005

3.18.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.18.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.18.3.3 Completing Specific Fields

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

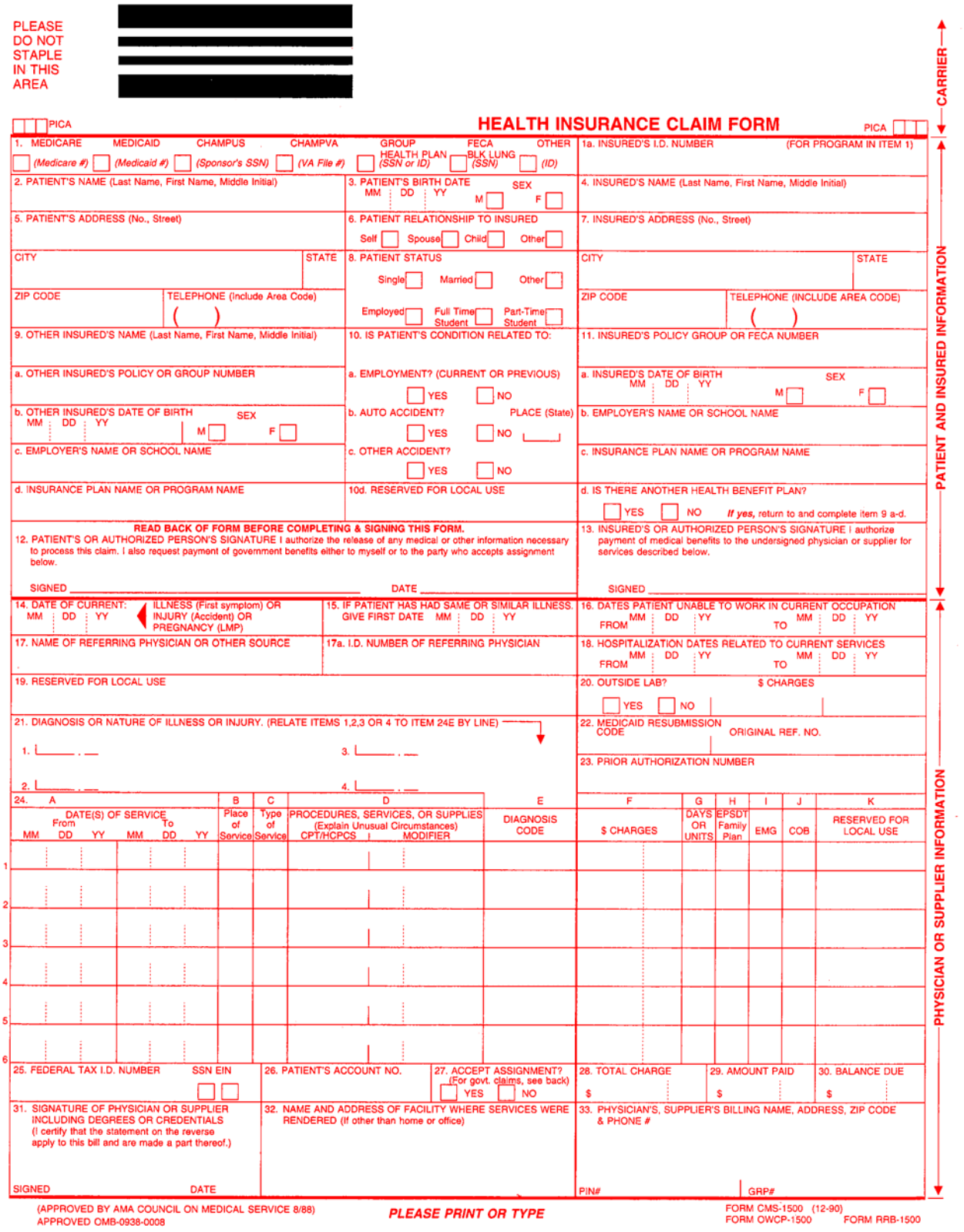
The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit participant ID number exactly as it appears on the plastic participant ID card.
2	Patient's Name	Required	Enter the participant's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable.	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the policy number.

Field	Field Name	Use	Directions
9b	Other Insured's Date of Birth/Sex	Required if applicable.	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable.	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable.	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable.	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection participant. Enter the referring physician's Medicaid provider number. For Healthy Connections participants, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	Enter the prior authorization number from DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, year). **Example:** November 24, 2005 becomes 11242005 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.

Field	Field Name	Use	Directions
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Desired	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.18.3.4 Sample Paper Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500